

Lehigh Valley Health Network LVHN Scholarly Works

Better Medicine

Newsletters

Fall 2014

Better Medicine

Lehigh Valley Health Network

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How Physician Liaisons Can Help Primary Care Physicians



Robin Fritsch
Physician liaison manager



Andrea Parry
Physician liaison



Patricia Egan
Physician liaison



Linda Horn
Physician liaison

By Robin Fritsch, manager, LVHN physician liaison program

Many physicians throughout our region see patients who receive care at a Lehigh Valley Health Network (LVHN) facility. Our physician liaison program is designed to make you and your patients' interactions with LVHN as seamless as possible.

We currently have three liaisons who are resources for doctors and office staff throughout our region — whether or not you are currently affiliated with LVHN or on our medical staff. Our liaisons:

- Keep you abreast of any changes at LVHN that may impact your practice
- Keep you apprised on new specialty physicians and services at LVHN (including facilitation of in-person meetings)
- Assist you with questions you may have about LVHN's care and services

Here is some feedback from a trio of primary care physicians who have benefitted from our services:

“Andi Parry is there for me whenever I have a concern or a question about LVHN. She keeps us updated on new doctors who join our health network. Through Andi I’ve also been able to attend events and meet other LVHN doctors and specialists face-to-face. Her work helps my staff and I know who to call when we need unusual consults like a pediatric neurologist.” — *Family medicine physician Michael Benavage, MD, North Catasauqua Area Medical Center*

“Pat Egan has been invaluable to me. She always returns my calls within 24 hours. Her years of experience lend a degree of expertise when I ask her for a referral. When I need to send a patient to a neurologist or neurosurgeon, she finds the right doctor who can see my patient soonest.” — *Family medicine physician Eugene Gorski, MD, Lehigh Valley Physician Group Family Medicine—Sugarloaf*

“The liaisons are wonderful. If I have a special case in my practice — a child with pediatric cancer or a urologic condition, an adult rheumatology patient who needs specialized pain management — I rely on Linda Horn, and she recommends the right place for care.” — *Family medicine physician Jeffrey Gold, DO, APFP, ACOFP, Oley Medical Associates*

To contact a physician liaison at LVHN, call 610-402-CARE.

Genetic Tests Diagnose Hereditary Colon-Rectal Cancers



Tara Namey
Genetic counselor

Risk assessment program brings guidance to patients, family members

As many as 20 percent of all newly diagnosed colon-rectal cancer patients at Lehigh Valley Health Network (LVHN) are referred into LVHN's [Cancer Risk Assessment and Genetic Assessment Program](#) to determine if their cancer is linked to a hereditary cancer syndrome.

Some are referred because an immunohistochemistry staining (IHC) test — which is performed on the cancer of every newly diagnosed colon-rectal cancer patient at LVHN — is able to identify cancers that are more likely the result of the hereditary Lynch syndrome. IHC alone, however, is not able to diagnose Lynch syndrome because approximately 15 percent of sporadic colon-rectal cancers will also show abnormal IHC staining.

The presence of abnormal IHC staining on a colon-rectal cancer will prompt a referral to a genetic counselor for further evaluation. From September 2013 through August 2014, 43 colon-rectal cancer patients were referred into the program.


“We do a four-generation family history and an assessment to determine if a patient meets criteria for additional genetic testing,” says LVHN senior genetic counselor and program manager Tara Namey, MS, LCGC. In addition, medical oncologists and surgeons may refer patients diagnosed before age 50 for genetic evaluation.

Genetic testing includes the search for inherited mutations in five genes known to be associated with Lynch

syndrome, a hereditary cancer susceptibility syndrome.

The team follows National Comprehensive Cancer Network guidelines to determine the specific tests to perform. For each patient, a board-certified genetic counselor provides consultations and discusses with patients the option to undergo specific genetic tests and the possible implications of each test, including how a test result may affect a patient's medical management and the need to notify at-risk family members.

Patients found to have Lynch syndrome and other hereditary cancer susceptibility syndromes are offered long-term follow-up in LVHN's multidisciplinary clinic of geneticists and medical oncologists. "The guidelines for management of hereditary cancer syndromes change frequently," Namey says. "Long-term follow-up helps make sure patients are getting their screenings, notifying all members of the family and following up with the appropriate specialists."



Surgical Techniques Individualize Care for Colon-Rectal Cancer



Robert Sinnott, DO
Colon-rectal surgery



Linda Lapos, MD
Colon-rectal surgery



Charles Andrews, MD
Radiation oncology

Robotics, laparoscopy and open techniques available

For colon-rectal cancer, surgery is almost always the main treatment method. At Lehigh Valley Health Network (LVHN), surgeons provide a full range of treatment options, including the latest in robotic surgical procedures, laparoscopic and other minimally invasive techniques.

“We approach these cancers minimally invasively, using laparoscopy or robotics, and keep the oncologic outcome as the top priority,” says LVHN colon-rectal surgeon [Robert Sinnott, DO](#), with Colon- Rectal Surgery Associates, PC. “These techniques usually provide smaller incisions, less pain, quicker return to normal activities and GI function, less narcotic use, and fewer wound and pulmonary complications.”

At LVHN, where surgeons performed 233 operative procedures for colon-rectal cancer in 2013, laparoscopic surgery for colon-rectal cancer is an established approach. However, a history of prior abdominal surgeries or tumor factors may limit laparoscopic surgery. Conversion to an open procedure may be necessary if the surgical field cannot be visualized well, or if the surgeon determines that it will provide the best oncologic outcome.

Use of robotics

The greatest utility of the [da Vinci® Si HD surgical robotics platform](#) for the treatment of colon-rectal cancer is primarily for rectal cancer. “The robot provides 3-D imaging, allowing us to better visualize structures deep in the pelvis,” Sinnott says. “That can lead to better functional outcomes for patients.” Sinnott has performed more than 50 robotic-assisted surgical resections in the last two years, mainly for rectal cancers.

Expertise in TEMS approach

Small early-stage rectal cancers or benign rectal polyps are sometimes treated with transanal endoscopic microsurgery (TEMS), a minimally invasive technique wherein the surgeon removes the growth without any external incision. “Our partner Mikhail Rakhmanine, MD, performs the highest volume of TEMS procedures within an hour’s drive,” says LVHN colon-rectal surgeon [Linda Lapos, MD](#), Sinnott’s colleague.

“Patients whose colon-rectal cancer is treated at high-volume centers by high-volume surgeons have better oncologic and better functional outcomes,” Sinnott says. Patients benefit from a multidisciplinary team approach.

All colon-rectal oncology cases are reviewed by LVHN's Colon-Rectal Tumor Board: surgeons, radiation and medical oncologists, geneticists and pathologists who meet weekly to recommend treatment options. Genetic testing can play a role in determining treatment plans, especially in patients diagnosed with colon-rectal cancer at a young age and in those with a family history of colon-rectal cancer.



Total mesorectal excision (TME) using da Vinci robotic system, low in the male pelvis.

Pre-operative radiation and chemotherapy

For some rectal tumors, pre-operative treatment is recommended with external beam radiation therapy and/or chemotherapy.

“If the surgeon can identify rectal tumors that have invaded the muscle layers of the rectum or involve any lymph nodes, we are asked to treat those to try and shrink the tumor,” says [Charles Andrews, MD](#), radiation oncologist with Allentown Radiation Oncologists and chair of the LVHN department of radiology. “That treatment has been known to improve survival as well as local tumor control.”

Sometimes preoperative treatment with radiation and chemotherapy can change the surgical resection or even eliminate the need for permanent colostomy.

To refer a patient for colon-rectal care, call 610-402-CARE.

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Treating Thyroid Nodules



Heiwon Chung, MD

Surgical oncology

[Watch a video to learn more about her.](#)

A comprehensive approach to diagnosis and management

Patients who present with a thyroid nodule, either upon palpable examination or as an incidental finding, may benefit from a referral to Lehigh Valley Health Network (LVHN) for its multidisciplinary approach to diagnosis, treatment and follow-up care.

Thyroid nodules — one or more tumors located on the thyroid gland — are common. By age 60, at least 50 percent of the population has one.¹ Nodules rarely produce symptoms or affect functioning, even in cases of malignancy.

“Thyroid nodules usually are detected from a study — such as ultrasound, CT scan, carotid screening or MRI of the spine — for issues unrelated to the thyroid,” says LVHN surgical oncologist [Heiwon Chung, MD](#), with LVPG Surgical Oncology. Only in rare cases does a benign nodule (toxic adenoma) cause the gland to produce excess amounts of thyroid hormone. Fortunately, greater than 90 percent of thyroid nodules are benign.²

Chung handles approximately five thyroid cancer cases per week, or approximately 200 per year, the highest volume in the Lehigh Valley.³ She also is among a select group of physicians nationwide with an endocrine certification in neck ultrasound, which is important for diagnosing and evaluating thyroid and parathyroid disorders.

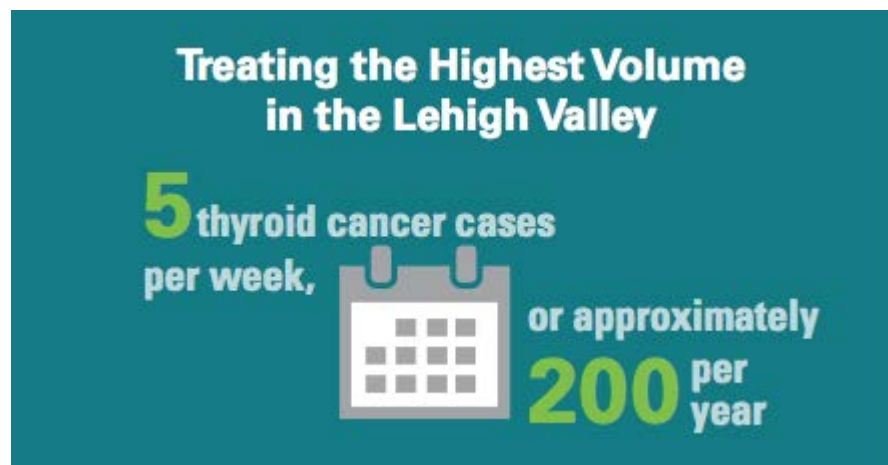


Left: Thyroid nodule. Right: Ultrasound is often used during a fine needle biopsy to help the doctor guide the needle.

Diagnosing disease

When Chung meets with patients, she analyzes their thyroid ultrasound imaging to determine if they require fine needle aspiration biopsy, a diagnostic test that's performed on the same visit with cytologists in her office. If the results are indeterminate, patients can undergo molecular testing on a tumor sample to assess the presence of malignancy. If none is found, patients routinely are monitored with ultrasound.

If a nodule is highly suspicious or confirmed to be malignant, surgery to remove half or the entire thyroid may be recommended. Chung takes special care to avoid the nerves that regulate the vocal cords and respiration. "I also place the incision in a natural skin groove in the neck to hide scarring," she says.



A personal touch

In most thyroid cancer cases, patients are cured with surgery. Still, they require thyroid hormone replacement. They also receive radioiodine therapy from LVHN endocrinologists with assistance from nuclear medicine physicians. Geneticists screen patients and families for their genetic susceptibility to thyroid cancer. Medical oncologists join the team for the rare cases involving metastatic disease.

What further differentiates the care patients receive from LVHN is that Chung herself is among the 10 percent of patients with a malignant thyroid nodule. "I've had thyroid cancer and surgery," she says, "so I understand a patient's mindset, worries and concerns."

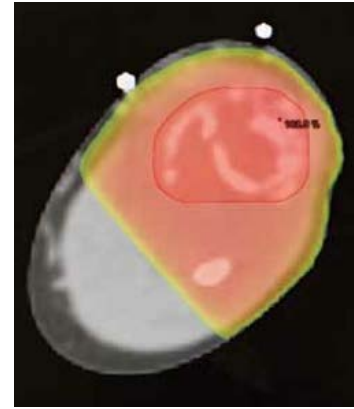
She shares her personal story in a video at [LVHN.org/Chung](https://www.lvhn.org/Chung).

“Children and adolescents diagnosed with a malignancy have a unique set of needs, and taking care of every patient and their family requires the concerted effort of a dedicated care team,” says LVHN radiation oncologist [Dennis Sopka, MD](#), with Allentown Radiation Oncology Associates.

Perch adds: “We have full-time physicists and dosimetrists who develop custom treatment plans for children, and we provide therapies that conform to the latest COG protocols for each cancer and subtype.”

Most areas with populations of less than 1 million do not have access to a COG-affiliated hospital with these kinds of capabilities. “LVHN has supported pediatric specialty care for more than 10 years, so we have been able to grow and recruit excellent physicians,” Hagstrom says. “We have the backing and resources to meet the highest standards of care.”

To refer a patient to pediatric hematology-oncology, call 888-402-LVHN.



Radiation treatment of the lower left leg. The tumor is outlined in red. Radiation treatment covers the shaded area.

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An Objective Look at Localized Prostate Cancer Treatment

Multidisciplinary approach offers guidance in one convenient visit

Patients with newly diagnosed early-stage prostate cancer face tough decisions about a variety of treatment options, including simple observation (“active surveillance”), curative surgery or radiation therapy. The choice can be confusing because one approach is not always superior to others. It also can be overwhelming, adding to the stress of a cancer diagnosis.

That’s why Lehigh Valley Health Network (LVHN) uses a [multidisciplinary clinic \(MDC\) approach](#) to prostate cancer, bringing patients and their family members together with a urologist and a radiation oncologist to discuss the treatment options in one convenient visit. Together, the team helps patients find the most suitable treatment course.



The urologic surgeon, radiation oncologist and nurse navigator who work together on a multidisciplinary consultation team explain what to expect when you receive care for prostate cancer at Lehigh Valley Health Network.



[Steven Perch, MD](#)
Radiation oncology



Joseph Feliciano, MD

Urologic oncology

[Watch a video to learn more about him.](#)



Angelo Baccala Jr., MD, PhD

Urologic oncology

[Watch a video to learn more about him.](#)

“Traditionally, when patients visit a urologist and a radiation oncologist in separate offices, it can take weeks to get all the information they need to make a decision,” says MDC head radiation oncologist [Steven Perch, MD](#), with Allentown Radiation Oncology Associates. “Here, we are all in the same room, so patients can ask questions and avoid getting mixed messages from their doctors.”

“As a surgeon, I may have a natural bias toward surgery, where a radiation oncologist may be biased toward radiation,” says MDC supporting urologic oncologist [Joseph Feliciano, MD](#), with LVPG Urology-Muhlenberg. “With the MDC approach, those biases cancel each other out. Ultimately, we can provide a unanimous recommendation and help steer that patient toward the treatment option best suited to his case.”

Fellowship-trained expertise

All surgeons in the prostate cancer MDC are fellowship-trained and use the latest techniques, including the [da](#)

Vinci® Si HD surgical robotics platform. “When you have six to eight years of robotic training throughout your residency and fellowship, getting hand-taught by the experts in the field, you can provide a different level of care than surgeons who have taken a course on robotic surgery,” says MDC head urologic oncologist [Angelo Baccala Jr., MD](#), with LVPG Urology-1250 Cedar Crest.

MDC radiation oncologists — all certified by the American Board of Radiology — have access to leading- edge therapeutic approaches, including external beam radiation therapy (available at both Lehigh Valley Hospital–Cedar Crest and LVH–Muhlenberg) and radioactive iodine-125 seed implant brachytherapy. “Relatively few hospitals offer brachytherapy or have treated a high volume of patients in that way,” Perch says. “We are by far the most experienced hospital doing that in this area.”

Total team care

The MDC also includes oncology nutritionists, physical therapists, social workers, psychosocial counselors and oncology financial coordinators. All clinical and supportive care is coordinated by nurse navigators, led by Chris Heffernan, RN. “They guide the patient through the entire process,” Baccala says. “They make sure the patient understands all aspects of our recommendations, and schedules follow-up appointments and lab work.



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Surgical Clipping and Endovascular Coiling of Cerebral Aneurysms



American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Comprehensive Stroke Center



[Darryn Shaff, MD](#)
Neurointerventional radiology



P. Mark Li, MD
Neurosurgery
[Watch a video to learn more about him.](#)

State-of-the-art treatment for complex cerebrovascular diseases

Although stroke is a leading cause of death in the U.S.¹, [cerebral aneurysms](#) that result in intracranial hemorrhage are less common² and require treatment in highly specialized settings such as Lehigh Valley Health Network's (LVHN) [Comprehensive Stroke Center \(CSC\)](#). The CSC certification is available only to high-volume stroke centers such as LVHN, which treated more than 150 aneurysms over the last two years.

Two types of treatment — surgical and endovascular — are offered at LVHN for cerebral aneurysm repair. These approaches are used to treat both ruptured aneurysms and unruptured aneurysms that may be detected incidentally. The goal is to eliminate blood flow into the aneurysm. The decision by LVHN's neurosurgeons and neurointerventionalists on which procedure to use is dependent upon a comprehensive evaluation of the patient's symptoms, medical history and imaging studies showing the aneurysm's location, size and shape.

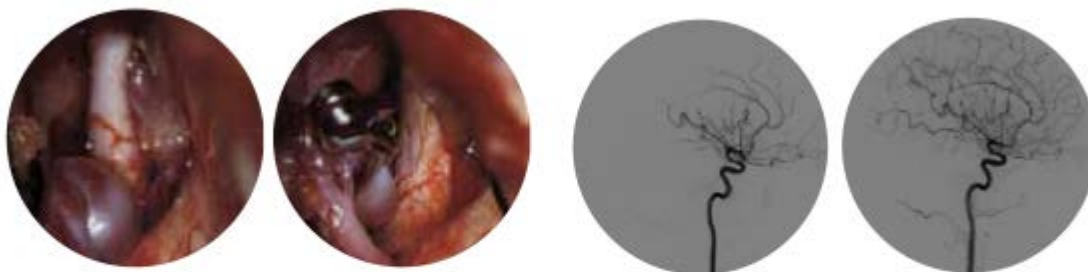
"We work together to do what's best for the patient," says neurointerventional radiologist [Darryn Shaff, MD](#), chief of neurointerventional radiology at LVHN.

Endovascular treatment

Introduced more than 20 years ago, endovascular coiling is used to treat the majority of LVHN patients who have cerebral aneurysms.

In this minimally invasive procedure, a neurointerventional radiologist uses X-ray guidance to navigate instruments through the femoral artery to the brain. Coils are advanced through a catheter into the aneurysm, occluding the aneurysm lumen. Stents sometimes are employed to remodel the neck of the aneurysm, facilitating coil embolization. Flow diversion, a newer technology, involves placing a specially constructed stent across the neck of the aneurysm to limit flow into the lesion, promoting thrombosis.

"Though endovascular procedures require general anesthesia, they are less invasive than surgical clipping and have lower procedural risk," Shaff says.



Before-and-after images using the clipping approach (two color images, far L) and coiling approach (two black-and-white images, near L).

For patients who have aneurysms not amenable to endovascular treatment, a neurosurgeon performs a craniotomy to separate the aneurysm from surrounding brain tissue. A titanium clip is used to seal off the aneurysm. Although clipping has been performed since the 1930s, today's microsurgical techniques allow for smaller incisions, and operative magnification and 3-D imaging help neurosurgeons verify proper clip placement.

"This is an intricate procedure, and high volumes are important in developing experience and efficiency," says

neurosurgeon [P. Mark Li, MD](#), with LVPG Neurosurgery and chief of neurosurgery at LVHN.

Stroke specialization

Many factors, from personnel to facilities, impact stroke care. LVHN maintains an organized multidisciplinary stroke team, neuro ICU services, two round-the-clock operating suites and interventionalists on call 24/7.

“We are responsive to the needs of our community and provide expert services so patients don’t have to leave the Lehigh Valley to receive stroke care,” Shaff says.

In the summer, Lehigh Valley Hospital became the first organization in the country to achieve recertification as a Comprehensive Stroke Center.

To refer a patient to neurosurgery, call 888-402-LVHN.

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Surgical Options for Hip Replacement



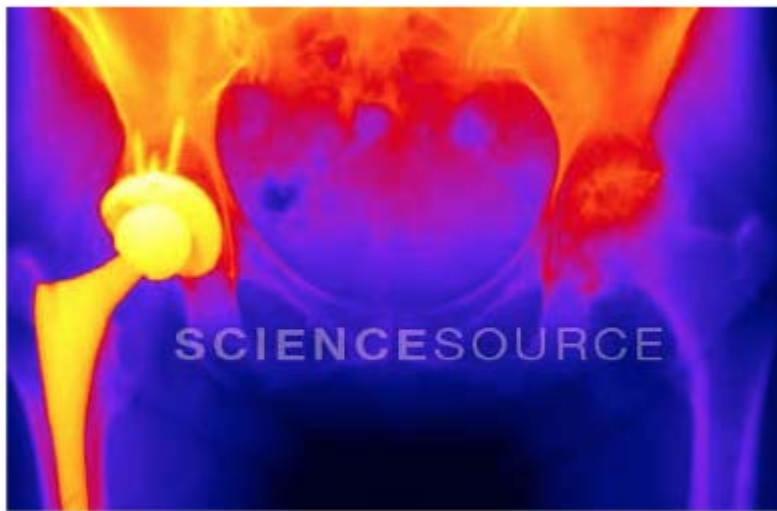
[Eric Lebby, MD](#)
Orthopedic surgery

Orthopedic specialists are fellowship-trained in joint replacement

Surgeons at Lehigh Valley Health Network (LVHN) last year performed 590 total hip replacement procedures, more than any other health care system in the Lehigh Valley. This volume, along with the experience and expertise of LVHN surgeons, is a significant factor in producing outcomes that allow patients to return to normal activities.

Joint specialists

LVHN is recognized as a [quality, safety and efficiency leader](#) in hip (and knee) replacement¹, also known as total joint arthroplasty. Patients are evaluated and treated by orthopedic joint replacement specialists — four of whom have fellowship-training in joint replacement. “This training and our volume of procedures produces efficiency, accuracy and quality,” says orthopedic surgeon [Eric Lebby, MD](#), with VSAS Orthopedics and chief of orthopedics at LVHN.



X-ray of a patient soon after a hip replacement.

Approaches to hip replacement

Each of the three surgical approaches to hip replacement — posterior (Moore or southern), lateral (Hardinge) and anterior (Smith-Peterson) — is defined by relation to the musculature of the hip. Despite extensive debate about the merits of each, there is no consensus about which to use. A great deal of marketing material proclaims that a particular approach may be “the best,” but neither orthopedic professional societies nor the literature support use of one approach over another.² Instead, the orthopedic surgeon typically chooses the approach at which he or she is most skilled and which he or she has found produces the best outcomes.

“All three approaches have stood the test of time,” Lebby says. “Each approach also has benefits and risks. In the proper hands, all three approaches have been shown to be extremely effective. That’s why the most important thing a physician can communicate to their patient is to pick a surgeon they are comfortable with and let the surgeon use his or her expertise to select the approach.”

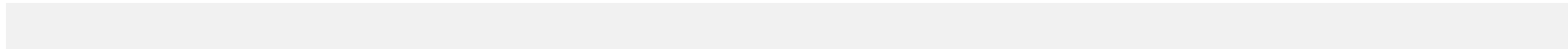
The advantages and potential limitations of the total hip replacement approaches are as follows:



- Posterior: Making an incision close to the buttocks, surgeons can easily view the hip capsule and bypass leg muscle. This approach offers excellent access to the femur and acetabulum, with possible leg length inequality and increased dislocation rate, although capsule repair mitigates dislocation risk.²
- Lateral: Surgeons using the lateral (side) approach elevate rather than cut the hip abductors to access and dislocate the joint in order to insert the prosthesis. The lateral approach provides an opportunity for fine tuning of leg length and a low dislocation rate, with hip abductor muscle weakness potentially leading to limp or lurch that may take time to improve.^{3,4,5}
- Anterior: Accessing the joint from the front of the hip, surgeons are able to keep the posterior capsule and muscles intact. This approach offers an opportunity for fine tuning of leg length and a low dislocation rate, with risk of femoral nerve damage and growth of bone.^{6,7,8}

8. “Myositis ossifications as a complication of hip arthroplasty”. D. Hamblen. *J Bone Joint Surg.* 1971: 53-B; 764.

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Empowering Patients With Complex Conditions



[Daniel Ray, MD](#)
Palliative medicine



[Jennifer Lindenmuth](#)
Palliative medicine



Jennifer Allen, MD
Palliative medicine

LVHN's palliative medicine program supports people with advanced serious illnesses

Patients with a life-limiting condition, such as metastatic cancer, or who have multiple complex illnesses, such as diabetes, coronary artery disease and kidney failure, often require extra time during office visits to manage symptoms and medical services. These are patients who can be most helped by Lehigh Valley Health Network's (LVHN) palliative medicine program: [OACIS \(optimizing advanced complex illness support\)](#).

"OACIS is for any patient with a serious medical condition who needs extra support," says [Daniel Ray, MD](#), a palliative medicine specialist and chief of the OACIS program.

Unlike hospice, OACIS isn't focused on a patient's mortality. "Some OACIS patients eventually recover from their illnesses," says [Jennifer Lindenmuth, MD](#), a palliative medicine specialist at LVHN. Rather, the goal is to help patients take control of their medical issues and treatment options and improve their quality of life. "Ultimately, we want these patients to be healthier and stay where they want to be, which is at home," Ray says.

A team approach

OACIS consists of physicians who are board-certified in palliative medicine, plus specially educated nurse practitioners, social workers, clergy and community groups. The program, which began in 2006, comprises home-based services, an inpatient consult service and an outpatient clinic. OACIS physicians spend an average of 80 minutes with patients in the hospital. Home-based consultations average 120 minutes.

"We have more time to sit down with patients and their families to talk about their illness, provide symptom management and help them live as well as they can, according to their values and goals," says [Jennifer Allen, MD](#), a palliative medicine specialist at LVHN. This extra support, which often is provided in a patient's home, can empower patients when they feel most vulnerable and help reduce hospitalizations and increase longevity. A study found that stage

IV lung cancer patients who received chemotherapy and palliative care lived two months longer than patients who received only chemotherapy.¹

Patients are referred to OACIS by their primary care or

OACIS physicians spend an average of 80 minutes with patients in the hospital; home-based consultations average 120 minutes.

subspecialty care physician. The OACIS team coordinates with the patient's primary care team. "Ideally, we'd like to see patients at the time of diagnosis of any serious, life-limiting illness," Ray says.

National recognition

OACIS is the only home-based palliative medicine program in the Lehigh Valley and one of the few in the nation. It recently

received the Circle of Life award, a national commendation from the American Hospital Association, which recognizes outstanding programs in palliative and end-of-life care.



To refer a patient to OACIS, call 610-402-CARE.

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Plastic Surgery Beneficial for Patients After Weight Loss



Randolph Wojcik Jr., MD

Plastic surgery

[Watch a video to learn more about him.](#)

Medically necessary procedures can be covered by insurance

Patients who've lost significant weight — either on their own or as a result of bariatric surgery — want to experience a more positive body image. Yet excess remaining skin (deflated areas where the skin fails to contract) often can lead to medical issues.

“Hanging skin can hold patients back from going to the beach or comfortably walking or jogging,” says Lehigh Valley Health Network (LVHN) plastic surgeon [Randolph Wojcik Jr., MD](#), with LVPG Plastic and Reconstructive Surgery-1243 Cedar Crest. It also can create irritating conditions such as intertrigo, a rash that appears in skin folds. “These patients have lost the weight, but draping skin is the final hurdle,” says Wojcik, LVHN’s associate chief of plastic surgery.

To help weight-loss patients recontour their bodies, LVHN board-certified plastic surgeons can excise excess skin and obscure the incisions. “The surgery can make an enormous difference in how patients feel about themselves after weight loss,” Wojcik says.

Determining medical necessity

The best candidates for this procedure are patients who had bariatric surgery at least one

year ago and/or who have been at their goal weight for at least six months. Excess skin after weight loss may appear on the face, arms, breasts, abdomen and thighs.

The surgery typically will result in an additional 5-25 pounds of weight loss. Health insurance typically will cover the procedure if it's medically necessary. "Primary care physicians and general surgeons should document with photos in the patient chart any rashes, wounds or skin infections after weight loss that have failed medical management," Wojcik says. "I'll write a letter on the patient's behalf as well."

Reducing out-of-pocket costs

Abdominoplasty (surgical removal of excess skin around the abdomen) is the most commonly covered procedure. Skin excision can cost a minimum of \$4,000, depending on the number of areas that need to be treated.

"We will see patients for an evaluation at any point, even if their weight hasn't yet plateaued," he says. To reduce out-of-pocket costs, procedures can be combined, such as the arms and the breasts, or the arms and abdomen. For patient safety, Wojcik limits surgery to six hours. Patients with excess skin in multiple areas will require more than one procedure.

To refer a weight-loss patient for a plastic surgery consultation, call 610-402-CARE.



Top: A weight-loss patient before her plastic surgery to remove excess skin. Bottom: The same patient six weeks postsurgery.

LVHN 1 of 15 Participants in Worldwide Robotics Training Trial

In April, Lehigh Valley Health Network (LVHN) joined with 14 other international robotics teaching centers in the fundamentals of robotic surgery (FRS) validation trial —the first multispecialty curriculum and examination designed to demonstrate and document technical competency and safety in robotics-assisted surgery.

LVHN's extensive experience in robotic surgeries and training expertise qualified it to be chosen as a testing site, along with other academic centers such as Beth Israel Hospital/Harvard and the University of Pennsylvania Health System. LVHN

surgeons have performed more than 4,000 robotics-based surgeries since the technology was adopted in 2008 — largely concentrated in treatment of gynecological oncology, lung and esophageal oncology, and colon oncology, as well as non-oncological specialties.



Martin Martino, MD

Gynecologic oncology

[Watch a video to learn more about him.](#)

"We have shown in a number of specialties at LVHN that robotic-assisted, minimally invasive surgery may provide better outcomes for patients," says gynecologic oncologist [Martin Martino, MD](#), medical director for LVHN's minimally invasive robotic surgery program. He has used robotics in more than 800 cases.

Open surgery rates for gynecological oncology cases involving hysterectomy have dropped from more than 90 percent to 18 percent at LVHN. Similarly, LVHN surgeons have proven that, compared with laparoscopic or open surgery, robotics-assisted surgery reduces blood loss, hospital stay and readmission rates.¹

The FRS validation trial is scheduled to be completed in mid-2015.

To refer a patient for minimally invasive robotic surgery, call 610-402-CARE.

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Robotic, Minimally Invasive Approach for Pelvic Floor Disorders

Two procedures offer 90-95 percent success rate



Folusho Tugbiyele, MD

Urogynecology

[Watch a video to learn more about him.](#)

Nearly 25 percent of U.S. women are affected by pelvic floor disorders, including urinary incontinence, pelvic organ prolapse and fecal incontinence.¹ Researchers estimate that by 2050, the incidence of these disorders may affect up to one-third of the adult female population.²

“Too often, patients don’t bring up these issues with their primary care physicians, regarding the symptoms as a natural part of aging,” says Lehigh Valley Health Network (LVHN) chief of urogynecology [Folusho Tugbiyele, MD](#), with LVPG Urogynecology-Muhlenberg. “As a result, these problems go untreated and can significantly affect quality of life.”

At LVHN, urogynecologic specialists offer minimally invasive surgeries to treat a range of pelvic floor disorders, using laparoscopic, vaginal and robotic approaches.

Robotic sacrocolpopexy

Sacrocolpopexy is a highly effective treatment for pelvic organ prolapse³; it involves placing a native tissue graft or mesh along the anterior and posterior walls of the vagina and anchoring it to the anterior longitudinal ligament of the sacrum.

"This procedure is particularly amenable to a robotic approach because we are working in the pelvic midline, a space which is difficult to access and maneuver in," Tugbiyele says. He and his colleagues perform more than 120 robotic sacrocolpopexy procedures annually using the [da Vinci® Si HD surgical system](#). "That's the most in the Lehigh Valley region," Tugbiyele says. The da Vinci system provides robotic arms that offer a greater range of motion than the human wrist, along with a 3-D, high-definition view of the surgical site.

"Clinical studies comparing robotic sacrocolpopexy with the open abdominal approach show similar success rates, up to 95 percent long term, but lower complication rates," Tugbiyele says. The most dramatic benefits occur during surgery and in the immediate postoperative period.

"Patients experience less pain, scarring and blood loss — an average of 25 ccs, compared with 200 ccs during an open abdominal procedure," Tugbiyele says. "They experience less post-op pain and lower risk for infection, and they leave the same day or the day after the procedure. Average recovery time is four to six weeks, about two weeks less than an abdominal procedure. We often need to remind patients not to take on too much too soon because they generally feel fine after they return home."

Midurethral sling

The midurethral sling is the standard of care for surgical treatment of stress urinary incontinence.⁴ The procedure involves placing a small mesh strip through the vagina under the midurethra to support it in a normal position. There are also general risks associated with surgery more than 200 midurethral sling procedures annually with a 90-95 percent success rate.

"Patients may suffer for years before bringing up the issue of urinary incontinence with their primary care physicians," Tugbiyele says. "Physicians should ask the simple question, 'Are you having any problems with leaking urine?' to get the conversation started."

"Sacrocolpopexy and the midurethral sling are gold-standard approaches to using synthetic mesh in modern pelvic floor reconstructive surgery," Tugbiyele says.

"These are not to be confused with transvaginal mesh (TVM) procedures, which involve placing larger, more dense mesh products to address vaginal prolapse.

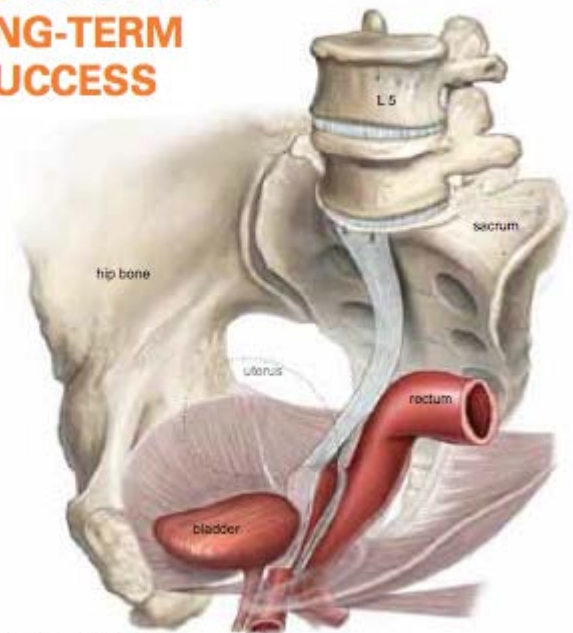
Those procedures carry a high risk for erosion and came under scrutiny by the FDA in recent years."

A center of excellence

LVHN is a Center of Excellence in Minimally Invasive Gynecology (COEMIGTM), a certification awarded by the AAGL (formerly the American Association of Gynecologic Laparoscopists) after a rigorous site inspection and records review. Tugbiyele also is a COEMIG-certified surgeon, reflecting the high volume of minimally invasive surgeries he performs and his outcomes.

Robotic Pelvic Floor Treatments

UP TO **95%**
LONG-TERM
SUCCESS



Pictured: Sacrocolpopexy

“Urogynecology is a relatively new field, so patients and even physicians may not be aware of all the leading-edge surgical and medical therapies we offer,” he says. “We take a customized approach to every patient, presenting them with a full scope of options, resolving their issues and keeping referring physicians completely informed at each step.”

To refer a patient to urogynecology, call 610-402-CARE.

Fall 2014



A Multidisciplinary Approach to Pelvic Pain



[Joseph Patruno, MD](#)
Gynecology

The Chronic Pelvic Pain and Vulvar Disorder Clinic at Lehigh Valley Health Network's (LVHN) Center for Women's Medicine offers specialized care for women experiencing the following issues:

- Endometriosis
- Vulvodynia
- Interstitial cystitis
- Tension myalgia
- Pelvic pain syndrome
- Pudendal neuralgia
- Discomfort during sexual relations
- Bladder and bowel pain syndromes
- Abdominal adhesions
- Pelvic support issues

"We tend to see patients after traditional treatments have failed," says gynecologist and clinic director [Joseph Patruno, MD](#). Patients undergo a complete evaluation, which includes imaging studies and consultations with referring physicians, to determine the patterns of pain and potential causes.

Physicians follow a multimodal approach to treatment, employing medications, painkilling injections for nerves and muscles (including Botox®), and laparoscopic surgery. Clinic physicians also provide referrals to LVHN pelvic

rehabilitation specialists, who offer expertise in treating tension myalgia, sexual pain and vulvodynia.

“We are available to take over or comanage a patient’s care,” Patruno says. “We also have access to the entire network of LVHN specialists to offer patients complete emotional and medical support.”

To refer a patient to the clinic, call 610-402-CARE.

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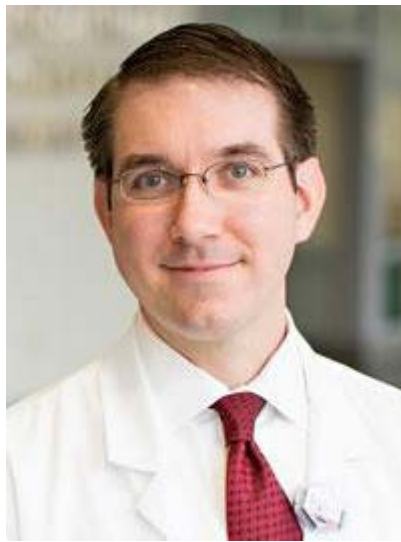
Providing Local Access to National Pediatric Oncology Protocols



J. Nathan Hagstrom, MD
Hematology-oncology



Steven Perch, MD
Radiation oncology



[Dennis Sopka, MD](#)
Radiation oncology

Latest therapies, cog membership help area children with cancer

Pediatric cancers like leukemia and lymphoma require access to the latest protocols and pharmaceuticals, sophisticated equipment and extensive clinical expertise. For these reasons, families in underserved communities often must travel to large urban hospitals for treatment — a significant hardship, as many children require weekly treatment for extended periods.

[Children's Hospital at Lehigh Valley Hospital](#) provides local families with close-to-home access. "Leukemia and lymphoma require multimodal therapy that can encompass chemotherapy, radiation oncology and surgery for biopsies and placement of central venous catheters," says Lehigh Valley Health Network (LVHN) hematologist-oncologist [J. Nathan Hagstrom, MD](#), LVHN's chair of pediatrics. "We can perform all of these therapies locally."

World-class therapies

The pediatric hematology-oncology program with LVPG Pediatric Endocrinology-17th Street is part of Children's Oncology Group (COG), the largest international consortium of pediatric cancer hospitals and clinicians. As such, patients are treated according to the same protocols as those receiving care at the world's foremost cancer centers.

"Nationwide, it is a high priority to enroll pediatric patients in clinical trials, so we can make progress in treating these rare diseases and make sure all children with cancer get the latest and best treatment," says LVHN radiation oncologist [Steven Perch, MD](#), with Allentown Radiation Oncology Associates. "As a COG member, we can participate in about

100 nationwide clinical trials specific to a wide variety of different types of pediatric malignancies."

A team effort

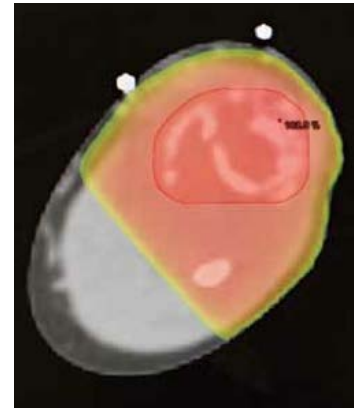
LVHN physicians have many decades of combined experience treating pediatric cancers, and the program's nurses, radiologists, pediatric anesthesiologists and supportive care specialists have extensive experience treating leukemia and lymphoma. LVHN also provides comprehensive radiation oncology services for lymphoma, using the latest linear accelerator and high-energy X-ray equipment.

“Children and adolescents diagnosed with a malignancy have a unique set of needs, and taking care of every patient and their family requires the concerted effort of a dedicated care team,” says LVHN radiation oncologist [Dennis Sopka, MD](#), with Allentown Radiation Oncology Associates.

Perch adds: “We have full-time physicists and dosimetrists who develop custom treatment plans for children, and we provide therapies that conform to the latest COG protocols for each cancer and subtype.”

Most areas with populations of less than 1 million do not have access to a COG-affiliated hospital with these kinds of capabilities. “LVHN has supported pediatric specialty care for more than 10 years, so we have been able to grow and recruit excellent physicians,” Hagstrom says. “We have the backing and resources to meet the highest standards of care.”

To refer a patient to pediatric hematology-oncology, call 888-402-LVHN.



Radiation treatment of the lower left leg. The tumor is outlined in red. Radiation treatment covers the shaded area.

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